MassHealth Adult Disability Supplement
Instructions for Completing the Supplement

You have indicated that you have a disability. Disability standards require that the disability has lasted or is expected to last at least 12 months.

MassHealth's Disability Evaluation Service (DES) will review your disability. As a result, it is **very important** that you **complete** the attached MassHealth Adult Disability Supplement.

To receive MassHealth based on your disability you need to tell us:

- information about your medical providers (the doctors and medical facilities where you have received treatment); and
- information about yourself: your work history for the past 15 years, your educational background, and your daily activities.

Completing the Disability Supplement will give us this information and will help us make a decision promptly.

Please read the following instructions before beginning.

- Print, type, or write clearly and complete the supplement to the best of your ability.
- Sign and date a Medical Release Form for **each medical provider** you listed on the supplement.

After you have completed the supplement and submitted it to your MassHealth Enrollment Center, the supplement will be forwarded to the DES for review. The DES will request your medical records from the providers you have listed. If more information is needed, or if further tests are required, a member of the DES will contact you.

Your eligibility will be determined more quickly if **all items** on the supplement are completed. If you have any questions or need help with the supplement, you may contact a MassHealth eligibility worker at the number listed below. You may also call the DES Disability Supplement Hotline for help in filling out the supplement at 1-888-497-9890.

_____ (_____)_____

MassHealth Eligibility Worker Telephone Number

MassHealth Adult Disability Supplement

Contact your MassHealth Enrollment Center if you need help with this form. You may also call the DES Disability Supplement Hotline at 1-888-497-9890.

Information about person claiming a disability.

Name (Last, First, MI)		Social Security Number - -
Street Address	Date of Birth ____/_____/____	Sex: ☐ M ☐ F
City/Town	State	Zip
Head of Household Name (if different)	Head of Household Social Security Number	Telephone Number ( )

Fill out all sections of this form. If some sections are not filled out, we may not be able to decide if you are disabled.

We may need to schedule a medical exam for you. What are the best days and times for you to go to an appointment? Please check two or more.

☐ Monday A.M.	☐ Tuesday A.M.	☐ Wednesday A.M.	☐ Thursday A.M.	☐ Friday A.M.
☐ Monday P.M.	☐ Tuesday P.M.	☐ Wednesday P.M.	☐ Thursday P.M.	☐ Friday P.M.

Part 1. Information about Your Health Problems

1a. List and describe all your medical and mental health problems. If you are getting treatment for the problem, please tell us what kind of treatment.

1b. If these problems cause you pain, tell us where you hurt and tell us what activities you find hard to do. (Use a separate piece of paper if necessary.)

2. When did each of these problems first bother you? Dates: _____

Part 1. Information about Your Health Problems (cont.)

3. Please tell us what medicines you take and how many times a day. (Be sure to include prescription and nonprescription medicines.)

Medicine	How many times a day	Cost per month	Describe any side effects you have.

4a. Are you working? ☐ Yes ☐ No

4b. If **no**, when did you stop working? Date: _____

4c. Did you stop working because of your health problems? ☐ Yes ☐ No If yes, explain: _____

_____

_____

_____

4d. Explain how your health problems now keep you from working. _____

_____

_____

_____

4e. While you worked, did your health problems cause you to change:

Your job duties? ☐ Yes ☐ No If yes, explain: _____

_____

_____

_____

Your hours of work? ☐ Yes ☐ No If yes, explain: _____

_____

_____

_____

Your attendance? ☐ Yes ☐ No If yes, explain: _____

_____

_____

_____

Anything else about your work? ☐ Yes ☐ No If yes, explain: _____

_____

_____

_____

Part 2. Information about your Doctors, Hospitals, Health Centers, and Clinics (Include the names of all of the people who help you, such as a therapist, social worker, or counselor.)

If you do not have a doctor currently treating some or all of your medical and mental health problems, check here: ☐

Please complete the following about any health care you have received since your health problems began. If you need more space, please use a separate piece of paper.

1. Name of **primary-care provider or doctor (if you have one):**	
Reason for visit:	How often do you visit?
Complete address where you were treated:	Telephone Number: ( )
When was your last visit? ☐ past month ☐ past 6 months ☐ past year ☐ longer than a year	

2. Name of **doctor, hospital, health center, or others:**	
Reason for visit:	How often do you visit?
Complete address where you were treated:	Telephone Number: ( )
When was your last visit? ☐ past month ☐ past 6 months ☐ past year ☐ longer than a year	

3. Name of **doctor, hospital, health center, or others:**	
Reason for visit:	How often do you visit?
Complete address where you were treated:	Telephone Number: ( )
When was your last visit? ☐ past month ☐ past 6 months ☐ past year ☐ longer than a year	

4. Name of **doctor, hospital, health center, or others:**	
Reason for visit:	How often do you visit?
Complete address where you were treated:	Telephone Number: ( )
When was your last visit? ☐ past month ☐ past 6 months ☐ past year ☐ longer than a year	

5. Name of **doctor, hospital, health center, or others:**	
Reason for visit:	How often do you visit?
Complete address where you were treated:	Telephone Number: ( )
When was your last visit? ☐ past month ☐ past 6 months ☐ past year ☐ longer than a year	

Please fill out completely one of the following Medical Release Forms for **each doctor**, hospital, health center, or clinic listed above. Be sure to sign and date each form. If you need more copies of the Medical Release Form, call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss).

I authorize the DES to contact any of these providers to get my medical records.

Signature of member or applicant _____ Date _____

Part 3. Information about Where You Live

1. Where do you live? (Check one.)

☐ House	☐ Group Home	☐ State Institution	☐ Rehab Hospital
☐ Apartment	☐ Homeless	☐ Nursing Home	☐ Other (describe):
☐ Rooming House			

2. Do you live alone? ☐ Yes ☐ No

Part 4. Information about Your Activities

1. Are you: ☐ Right Handed? ☐ Left Handed?
2. How often do you do the following activities? (Check one for each activity.)

Activity	Every Day (✓)	Once a Week (✓)	Once a Month (✓)	Never (✓)	Need Help?
Go to a restaurant					☐ Yes ☐ No
Go shopping					☐ Yes ☐ No
Go to meetings					☐ Yes ☐ No
Go to Post Office					☐ Yes ☐ No
Visit the doctor					☐ Yes ☐ No
Visit friends					☐ Yes ☐ No
Visit relatives					☐ Yes ☐ No
Go to a movie					☐ Yes ☐ No
Read					☐ Yes ☐ No
Watch TV					☐ Yes ☐ No
Play sports					☐ Yes ☐ No
Listen to music					☐ Yes ☐ No
Go fishing					☐ Yes ☐ No
Ride a bicycle					☐ Yes ☐ No
Go bowling					☐ Yes ☐ No
Play games					☐ Yes ☐ No
Talk on phone					☐ Yes ☐ No
Arts and crafts					☐ Yes ☐ No
Go hunting					☐ Yes ☐ No
Take care of children					☐ Yes ☐ No
Other (describe):					☐ Yes ☐ No

If you said you needed help with any of the above activities, or if you have problems doing any of these activities, please explain here: _____

_____

_____

_____

_____

_____

_____

Part 4. Information about Your Activities (cont.)

3. How often do you do the following activities? (Check one for each activity.)

Activity	All the time (✓)	Often (✓)	Not very often (✓)	Never (✓)	Need Help?
Sit					☐ Yes ☐ No
Stand					☐ Yes ☐ No
Walk					☐ Yes ☐ No
Bend					☐ Yes ☐ No
Reach					☐ Yes ☐ No
Lift					☐ Yes ☐ No
Go outside					☐ Yes ☐ No
Use your hands					☐ Yes ☐ No

If you said you needed help with any of these activities, or if you have problems doing any of these activities, please explain here: _____

_____

Do you have trouble: (If you answer "yes" to any of the following three questions, please check the box that best describes your problem.)

Remembering? ☐ Yes ☐ No If yes, ☐ long-term memory loss? ☐ short-term memory loss? ☐ frequent forgetfulness? ☐ occasional forgetfulness?

Seeing? ☐ Yes ☐ No If yes, ☐ wear or need glasses? ☐ have blurred vision associated with your sight impairment or medication?

Hearing? ☐ Yes ☐ No If yes, ☐ wear or need hearing aids?

4. Can you do any of the following activities? (Check either Yes, No, or Need Help after each activity.)

Activity	Yes	No	Need Help?	Activity	Yes	No	Need Help?
Shop for Food			☐ Yes ☐ No	Handle Money			☐ Yes ☐ No
Plan Meals			☐ Yes ☐ No	Make Beds			☐ Yes ☐ No
Cook			☐ Yes ☐ No	Empty Trash			☐ Yes ☐ No
Wash Dishes			☐ Yes ☐ No	Mow the Lawn			☐ Yes ☐ No
Do laundry			☐ Yes ☐ No	Vacuum			☐ Yes ☐ No
Dust			☐ Yes ☐ No				

If you said you needed help with any of these activities, or if you have problems doing any of these activities, please explain here: _____

_____

5. Do you have a driver's license? ☐ Yes ☐ No

6. Check all the different ways you get from one place to another.

☐ Drive a car	☐ Walk	☐ Other (describe):
☐ Take a train	☐ Take a bus	
☐ Have friends or relatives give you a ride	☐ Ride a bicycle	
☐ Take a handicapped van	☐ Take a cab	

Explain any problems you have getting from one place to another: _____

_____

_____

7. Do you need help to get places? ☐ Yes ☐ No

If yes, explain: _____

Part 5. Information about Your Language

1. Do you speak English? ☐ Yes ☐ No Do you understand English? ☐ Yes ☐ No
   Do you read English? ☐ Yes ☐ No Do you write English? ☐ Yes ☐ No

2. What is your primary language? _____ Do you read and write in your primary language? ☐ Yes ☐ No

3. Do you read and write in any other language(s)? ☐ Yes ☐ No If yes, what language(s)?_____

Part 6. Information about Your Education

1. Check the highest grade of school you completed.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17+

2. What year did you finish this grade? _____ 3. Where did you attend school? _____

4. If you completed more than 12 years of school, please list your degree and major field of study. _____

_____

5. While you were in school, did you attend any special-education classes? ☐ Yes ☐ No ☐ Don't know If yes, or you don't know, you may want to submit your school records with this supplement.

   Comments:_____

   _____

6. Do you have additional training? ☐ Yes ☐ No If yes, check the type of training and complete the sections below.

Type of Training	Dates Attended	Completed	License/Certification
Building Trades		☐ Yes ☐ No	☐ Yes ☐ No
Electronics		☐ Yes ☐ No	☐ Yes ☐ No
Cooking		☐ Yes ☐ No	☐ Yes ☐ No
Auto Mechanic		☐ Yes ☐ No	☐ Yes ☐ No
Computers		☐ Yes ☐ No	☐ Yes ☐ No
Business School		☐ Yes ☐ No	☐ Yes ☐ No
Cosmetology		☐ Yes ☐ No	☐ Yes ☐ No
Hairdressing		☐ Yes ☐ No	☐ Yes ☐ No
Nurse's Aide		☐ Yes ☐ No	☐ Yes ☐ No
Other (describe):		☐ Yes ☐ No	☐ Yes ☐ No

Part 7. Information about Benefits

Are you currently receiving or have you ever received benefits from:		If **yes**, complete the following dates: Start (month/year)	Stop (month/year)
MassHealth	☐ Yes ☐ No		
Social Security Disability (SSDI)	☐ Yes ☐ No		
Worker's compensation	☐ Yes ☐ No		
Unemployment compensation	☐ Yes ☐ No		
EAEDC	☐ Yes ☐ No		
TAFDC	☐ Yes ☐ No		
SSI	☐ Yes ☐ No		

Part 8. Information about Your Work

- If you have **not worked** in the last 15 years, or you have **never worked,** please check here ☐, and go to Part 9.
- If you **have worked** in the last 15 years, please check here ☐, and fill out Part 8 completely.

1. List all of the jobs you have held in the last **15 years**. Do the best you can. Start with your most recent or current job. (If you need more space, use a separate piece of paper.)

Job Title: ______________________ Dates Worked: From: ____________ (Month/Year) To: ____________ (Month/Year)

Job Duties: (What did you do?) ______________________________

____

____

____

Number of hours a week worked: ____________ Hourly Pay: $ ____________

Reason for Leaving: ______________________________

Job Title: ______________________ Dates Worked: From: ____________ (Month/Year) To: ____________ (Month/Year)

Job Duties: (What did you do?) ______________________________

____

____

____

Number of hours a week worked: ____________ Hourly Pay: $ ____________

Reason for Leaving: ______________________________

Job Title: ______________________ Dates Worked: From: ____________ (Month/Year) To: ____________ (Month/Year)

Job Duties: (What did you do?) ______________________________

____

____

____

Number of hours a week worked: ____________ Hourly Pay: $ ____________

Reason for Leaving: ______________________________

Job Title: ______________________ Dates Worked: From: ____________ (Month/Year) To: ____________ (Month/Year)

Job Duties: (What did you do?) ______________________________

____

____

____

Number of hours a week worked: ____________ Hourly Pay: $ ____________

Reason for Leaving: ______________________________

Part 8. Information about Your Work (cont.)

2. What were your main work activities in your most recent job? (Check all that apply.)

☐ Driving	☐ Operating Machines	☐ Helping People
☐ Cleaning	☐ Moving Materials	☐ Doing Paperwork
☐ Assembly	☐ Building	☐ Repairing
☐ Typing	☐ Filing	☐ Other (describe):
☐ Serving People	☐ Counting & Packing	

3. Did you use any of the following in your job? (Check all that apply.)

☐ Hand Tools	☐ Office Machines	☐ Fork Lift
☐ Power Tools	☐ Cash Register	☐ Other (describe):

4. Circle the number of hours in a day that you did the following activities in your most recent job.

Activity	Hours in a Day								
Walk	0	1	2	3	4	5	6	7	8
Stand	0	1	2	3	4	5	6	7	8
Sit	0	1	2	3	4	5	6	7	8
Bend	0	1	2	3	4	5	6	7	8
Reach	0	1	2	3	4	5	6	7	8

5. Check the heaviest weight you lifted on your most recent job:

☐ Less than 10 lbs.	☐ 10 lbs.	☐ 20 lbs.	☐ 25 lbs.
☐ 50 lbs.	☐ 100 lbs.	☐ More than 100 lbs.	

6. Check the weight you most often lifted or carried:

☐ Less than 10 lbs.	☐ 10 lbs.	☐ 20 lbs.	☐ 25 lbs.
☐ 50 lbs.	☐ More than 50 lbs.		

Part 9: Comments and Signature

Applicant/Member Comments and Signature

Use this space to write more information, if needed.

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of applicant/member/eligibility representative/guardian Date

Fill out this block **only** if you want someone to represent you.

Eligibility Representative:

If this form is being filled out by someone who has the legal authority to act on behalf of the applicant/member (such as the parent of a minor child, an eligibility representative, or a legal guardian), give us the following information:

Signature of person filling out this form:_____

Print name:_____

Authority of person filling out this form on behalf of the applicant/member:_____

The DES may send copies of notices to the eligibility representative. This area does **not** authorize release of medical records.

If you needed help to fill out this form, please answer these questions and give us the name(s) of the person(s) who helped you and what relationship, if any, the person(s) is to you.

1. Did you need help to fill out this form? ☐ Yes ☐ No
2. If yes, who helped you?_____
3. What is that person's relationship to you?_____
4. Why did you need help?_____

For Office Use Only
MassHealth Worker's Comments and Signature

_____

_____

_____

_____

_____

_____ _____

Signature of Worker Date